Ninilchik Traditional Council Community Clinic
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Integrative Healthcare Questionnaire

Congratulations on your decision to move further on the path to optimal health! We're here to educate and support you as part of our commitment in partnering with you to bring about better health. Please fill out this form as completely and as accurately as possible.

GENERAL INFORMATION

TODAY'S DATE: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Place of Birth: _____ Gender Identified: _____

Occupation: _____ Referred By: _____

Please check appropriate box(es):

- ☐ African American
- ☐ Alaska Native/ American Indian
- ☐ Hispanic
- ☐ Caucasian
- ☐ Mediterranean
- ☐ Northern European
- ☐ Asian
- ☐ Other

MEDICAL CARE HISTORY

PREVENTIVE TESTS *Check box if yes and provide date*	DATE
☐ Full Physical Exam	
☐ Bone Density	
☐ Colonoscopy	
☐ Cardiac Stress Test	
☐ EKG	
☐ Hemoccult (stool test for blood)	
☐ Mammogram	
☐ PAP Smear	
☐ PSA	
☐ Shingles Vaccine	
☐ Pneumovax	
☐ Other _____	

SURGICAL HISTORY *Check box if yes and provide date*	DATE
☐ Appendectomy	
☐ Hysterectomy	
_____ Ovaries Removed: Right (R) / Left (L) / Both(B)	
☐ Gall Bladder	
☐ Hernia	
☐ Tonsillectomy/Adenoidectomy	
☐ Joint Replacement - Knee/Hip	
☐ Heart Surgery *(type)* _____	
☐ Angioplasty or Stent	
☐ Pacemaker	
☐ Other _____	

HOSPITALIZATIONS

Date	Reason for Hospitalization

SPECIALIST CARE ***Please list all physicians currently managing your care.***

Physician Name	Medical Specialty	Issue(s) Being Managed

MEDICAL SYMPTOM QUESTIONNAIRE

BASED ON THE PAST 30 DAYS rate each of the following symptoms based upon your typical health profile.

NAME _____ DATE _____

Please use the scale shown below to describe the severity of your symptom (please total each section)

0 ***Never* or *almost never* have the symptom**
1 ***Occasionally* have it, effect is *not severe***
2 ***Occasionally* have it, effect is *severe***
3 ***Frequently* have it, effect is *not severe***
4 ***Frequently* have it, effect is *severe***

HEAD
_____ Headaches
_____ Dizziness/Faintness
_____ Insomnia
_____ **SUBTOTAL (this section)**

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Dark circles under eyes
_____ Vision problems (excluding near or farsighted)
_____ **SUBTOTAL (this section)**

EARS
_____ Itchy ears
_____ Frequent ear infections
_____ Popping of ears
_____ Ringing in ears
_____ **SUBTOTAL (this section)**

NOSE
_____ Stuffy nose/Excessive mucus formation
_____ Sinus problems
_____ Hay fever/Sneezing attacks
_____ Nose bleeding
_____ **SUBTOTAL (this section)**

MOUTH/
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/Discolored tongue, gums, lips
_____ Canker sores
_____ **SUBTOTAL (this section)**

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Excessive hair growth
_____ Excessive sweating/Body odor
_____ Flushing, hot flashes
_____ **SUBTOTAL (this section)**

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ **SUBTOTAL (this section)**

LUNGS
_____ Chest congestion
_____ Asthma, frequent bronchitis
_____ Difficulty breathing
_____ Frequent coughing
_____ **SUBTOTAL (this section)**

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea, loose stools
_____ Constipation, hard/infrequent stools
_____ Bloated feeling
_____ Belching, passing gas, burping
_____ Heartburn/acid taste in mouth
_____ Intestinal/stomach pain
_____ **SUBTOTAL (this section)**

JOINTS / MUSCLE
_____ Pain or aches in joints/Arthritis
_____ Warm, swollen joints
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Muscle weakness
_____ **SUBTOTAL (this section)**

WEIGHT
_____ Excessive eating/drinking
_____ Strong/Excessive craving certain foods
_____ Overweight/Obese
_____ Difficulty losing weight
_____ Water retention
_____ Difficulty gaining weight
_____ **SUBTOTAL (this section)**

ENERGY / ACTIVITY
_____ Fatigue from mental exhaustion
_____ Fatigue from emotional exhaustion
_____ Hyperactivity (mind or body)
_____ Restlessness (mind or body)
_____ **SUBTOTAL (this section)**

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Speech difficulty
_____ Learning disabilities
_____ **SUBTOTAL (this section)**

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression/Sadness
_____ Obsessive, compulsive behaviors
_____ **SUBTOTAL (this section)**

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ **SUBTOTAL (this section)**

TOTAL SUM OF ALL SECTIONS ABOVE: _____

PERSONALIZED HEALTH STRATEGY

*Please describe your **top two (2) health goals** you seek to strategically improve.*

GOAL #1:

GOAL #2:

COMPLAINTS/CONCERNS

When was the last time you felt well?

Did something trigger your change in health?

Is there anything that makes you feel worse?

Is there anything that makes you feel better?

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
example: Difficulty maintaining attention		✓		**example: elimination diet**	✓		

MEDICAL HISTORY

DISEASES/DIAGNOSES/CONDITIONS

Check appropriate box and provide date of onset
☑ = Past Condition (pc) ☑ = Ongoing Condition (oc)

pc	oc	GASTROINTESTINAL	date of onset
☐	☐	Irritable Bowel Syndrome	
☐	☐	Crohn's Disease	
☐	☐	Ulcerative Colitis	
☐	☐	Gastritis or Peptic Ulcer	
☐	☐	GERD (Acid Reflux)	
☐	☐	Celiac Disease	
☐	☐	Other_____	

pc	oc	CARDIOVASCULAR	date of onset
☐	☐	Heart Attack	
☐	☐	Poor Circulation	
☐	☐	Stroke	
☐	☐	High Cholesterol	
☐	☐	Arrhythmia (irregular beat)	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Heart Valve Disease	
☐	☐	Other _____	

pc	oc	METABOLIC/ENDOCRINE	date of onset
☐	☐	Type 1 Diabetes	
☐	☐	Type 2 Diabetes	
☐	☐	Hypoglycemia (low blood sugar)	
☐	☐	Metabolic Syndrome	
☐	☐	Insulin Resistance or Pre-diabetes	
☐	☐	Obesity/Overweight	
☐	☐	Hypothyroidism (underactive)	
☐	☐	Hyperthyroidism (overactive)	
☐	☐	Polycystic Ovarian Syndrome (PCOS)	
☐	☐	Infertility	
☐	☐	Other _____	

pc	oc	NEUROLOGIC/PSYCHIATRIC	date of onset
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Bipolar Disorder	
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	ADD/ADHD	
☐	☐	Autism	
☐	☐	Multiple Sclerosis	
☐	☐	Seizures	
☐	☐	Eating Disorder (Anorexia/Bulimia)	
☐	☐	Other _____	

pc	oc	GENITAL AND URINARY	date of onset
☐	☐	Kidney Stones	
☐	☐	Interstitial Cystitis	
☐	☐	Frequent Urinary Tract Infections	
☐	☐	Frequent Yeast Infections	
☐	☐	Erectile or Sexual Dysfunction	
☐	☐	Urinary Incontinence	
☐	☐	Other _____	

pc	oc	MUSCULOSKELETAL/PAIN	date of onset
☐	☐	Osteoarthritis	
☐	☐	Fibromyalgia	
☐	☐	Gout	
☐	☐	Chronic Pain Syndrome	
☐	☐	Other _____	

pc	oc	AUTOIMMUNE/INFLAMMATORY	date of onset
☐	☐	Chronic Fatigue Syndrome	
☐	☐	Autoimmune Disease	
☐	☐	Rheumatoid Arthritis	
☐	☐	Hashimoto's Thyroiditis	
☐	☐	Psoriasis	
☐	☐	Food Allergies	
☐	☐	Environmental Allergies	
☐	☐	Multiple Chemical Sensitivities	
☐	☐	Other _____	

pc	oc	PULMONARY/EAR-NOSE-THROAT	date of onset
☐	☐	Asthma	
☐	☐	Chronic Sinusitis	
☐	☐	Bronchitis	
☐	☐	COPD or Emphysema	
☐	☐	Pneumonia	
☐	☐	Sleep Apnea	
☐	☐	Other _____	

pc	oc	DERMATOLOGIC	date of onset
☐	☐	Eczema	
☐	☐	Vitiligo	
☐	☐	Acne	
☐	☐	Other _____	

pc	oc	CANCER	date of onset
☐	☐	Lung Cancer	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Ovarian Cancer	
☐	☐	Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Other _____	

FEMALE HISTORY

OBSTETRIC HISTORY *(Check box if yes and provide number of times)*

Pregnancies _____ Cesarean _____ Vaginal Deliveries _____

Miscarriage _____ Abortion _____ Living Children _____

Postpartum Depression Toxemia Gestational Diabetes Baby over 8 lbs

Breastfeeding For How Long? _____

MENSTRUAL HISTORY

Age at first period _____ Menses Frequency: every _____ days Menses Length: _____ days long

Describe your **current** menstrual cycle Regular Irregular Absent

Details: _____

Last Menstrual Period: _____ Date of Last PAP: _____

History of Abnormal PAP? Yes No If yes, date of abnormal PAP: _____

Current contraception? Birth Control Pill Condom Vasectomy IUD Hysterectomy None

Total years of hormonal contraception use? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES (circle all that apply)

Fibrocystic Breasts Endometriosis Fibroids Infertility

Painful Periods Heavy Periods PMS Menstrual Migraines

Are you in menopause (no menses in last 12 months)? No Yes (if yes, what age? _____)

If yes, Natural Surgical removal of ovaries reason for removal _____

Current use of hormone replacement therapy? None

(How Long? _____) Traditional Prescription

(How Long? _____) Bioidentical Hormone Replacement Therapy

Previous use of hormone replacement therapy? None

(How Long? _____) Traditional Prescription

(How Long? _____) Bioidentical Hormone Replacement Therapy

MENOPAUSAL SYMPTOMS (circle all that apply)

Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness

Night Sweats Sleep Problems Postmenopausal Bleeding Loss of Control of Urine

Headaches Palpitations Weight Gain Depression or Anxiety

MALE HISTORY

Have you had a PSA done? No Yes (Date of last PSA? _____)

PSA Level: 0-1 2-4 5-10 >10 Managing Urologist: _____

ANDROPAUSE SYMPTOMS (circle all that apply)

Fatigue Nocturia (urination at night) How many times per night? _____

Irritability Urgency/Hesitancy/Change in urinary stream

Decreased Libido Enlarged Prostate

Erectile Dysfunction

DIGESTIVE/DIETARY HISTORY

TYPICAL DIET: List the most common meal you eat or drink in each category-

Breakfast: _____ Beverage: _____

Lunch: _____ Beverage: _____

Dinner: _____ Beverage: _____

Snack: _____ Beverage: _____

How many cups of water do you drink a day? _____ Cups

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

If yes, ☐ within 30 min after eating ☐ after 1-2 hours of eating

Were there years where you took more than 3 courses of antibiotics per year? ☐ Yes ☐ No

Do you experience frequent yeast infections or toe fungal infections/athlete's foot? ☐ Yes ☐ No

Do you get sick from strong smells, chemicals or medications easier than most people? ☐ Yes ☐ No

Are there some foods to which you are allergic, intolerant or just seem to bother you?

Explain:

Do you suffer from allergies? ☐ Environmental ☐ Food

If environmental, are they. . . ☐ Seasonal ☐ All Year Long

Do you ever find blood in your stool? ☐ Yes ☐ No

How many bowel movements do you have in a typical day? <1 1 2 3 4 _____

If you answered <1, how often do you have a bowel movement? Every _____ days Since When? _____

Describe your typical bowel movement *(check all that apply)*

☐ Hard ☐ Soft ☐ Alternating Diarrhea/constipation ☐ Complete

☐ Pellet-like ☐ Loose ☐ Mucus in stool ☐ Incomplete

☐ Requires straining ☐ Watery ☐ Undigested food in stool

☐ Large ☐ Floating ☐ Strange color/odor

If you experience any digestive issues, when did they begin?

☐ Last 3-6 months ☐ Since childhood

☐ Last 6-12 months ☐ Can't remember

☐ _____ years ago

Have you ever been referred to a Gastroenterologist? ☐ No ☐ Yes Name:_____

Explain:

LIFESTYLE INFORMATION

SMOKING

Currently smoking? Yes No How many years? _____ Packs per day: _____

Attempts to quit: _____ Using what methods: _____

Previous smoking? Yes No How many years? _____ Packs per day: _____

Quit Date: _____

2nd hand smoke exposure? None Low Medium High

Current Past

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5oz wine, 12 oz beer, 1.5 oz liquor)*

None 1-3 4-6 7-10 >10 throughout the week weekends mostly

Do you frequently (more than 2x/week) take:

>1 drink per day for females

>2 drinks per day for males

Previous alcohol intake? None Mild Moderate High

Do you ever feel guilty about your alcohol consumption? Yes No

Do you notice a tolerance to alcohol (you can "hold" more than others)? Yes No

Do you notice you 'feel' your alcohol at very low amounts? Yes No

OTHER SUBSTANCES

Caffeine intake

Cups per day: Coffee: _____ Tea: _____ (Herbal Non-Herbal)

Caffeinated or Diet Beverages per day None 1 2 3 ≥4

List favorite type (e.g. Diet Coke, Pepsi, Red Bull, Monster, etc) _____

Do you often take caffeine to avoid fatigue? Yes No

EXERCISE

Current Exercise Program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency/week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Yoga/Pilates			
Sports/Leisure Activities *(golf, tennis, rollerblading, etc)*			

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

Do you usually sweat when exercising? Yes No

Obstacles or challenges with exercise: (check all that apply) Time Pain Energy

Other _____

LIFESTYLE INFORMATION

STRESS/COPING

1. Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No
2. Do you feel you can manage the stress in a healthy way? ☐ Yes ☐ No
3. Do you feel you make unhealthy choices due to high stress? ☐ Yes ☐ No
4. What is the level of stress in you life? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
5. How well do you manage stress in your life? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
6. Would you like to improve the way you manage stress? ☐ Yes ☐ No
7. Have you ever sought counseling? ☐ Yes ☐ No

Daily Stressors ***(rate on a scale of 1-10: 1=lowest, 10=highest)***

Work _____ Family _____ Social _____ Finances _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No

Check all that apply: ☐ Prayer ☐ Breathing ☐ Meditation
☐ Yoga ☐ Tai Chi ☐ Other _____

SLEEP/REST

How likely are you to doze off or fall asleep in the following situations using the scale below?

0 = Would never doze *2 = Moderate chance of dozing*
1 = Slight chance of dozing *3 = High chance of dozing*

Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (ex, a theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3

Average number of hours you sleep per night? ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling asleep at night? ☐ Yes ☐ No

If yes, how long does it usually take to fall sleep? _____

Do you have trouble staying asleep at night? ☐ Yes ☐ No

If yes, how long are you awake throughout the night? _____

How many times do you awaken throughout the night? _____

Please list any sleep aids (prescription or natural) or other methods tried:

GENETIC RISK ANALYSIS

Please place age at diagnosis where appropriate.	Mother	Father	Brother(s)	Brother(s)	Sister(s)	Sister(s)	Child(ren)	Child(ren)	Child(ren)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still alive)														
Age at death														
Colon Cancer														
Breast Cancer														
Other Cancers - List Type _____														
Heart Disease														
Stroke														
Hypertension														
Obesity/Overweight														
Diabetes														
High Cholesterol														
Arthritis (<60 years old)														
Multiple Sclerosis														
Rheumatoid Arthritis / Lupus / Psoriasis														
Ulcerative Colitis / Crohn's Disease														
Irritable Bowel Syndrome (IBS)														
Celiac Disease														
Asthma / Chronic Bronchitis														
Eczema/Hives														
Food Allergies or Sensitivities														
Environmental Sensitivities														
Multiple Chemical Sensitivities														
Dementia or Parkinson's														
Substance Abuse (alcoholism, drugs)														
Depression														
Anxiety														
ADHD														
Autism														
Thyroid Disorders														
Other _____														
Other _____														
Other _____														

MEDICATION HISTORY

Attach separate page as needed

CURRENT MEDICATIONS

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Use?

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Stopping?

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement	Strength	Dosing Schedule	Start Date (month/year)	Brand of Supplement

ALLERGIES (ENVIRONMENTAL, FOOD & DRUGS)

Allergen	Associated Symptoms	Treatment needed, if applicable

Life Stress Questionnaire

Name _____ Date_____

During the past two years, have you had any of the following things happen to you? If so, simply circle one of the numbers following those items (and **only those items** that apply to you). Circle only one number after each event which has occurred in your life recently.

	LIFE EVENT	Slight	Moderate	Great
Example:				
	Change in social activities	10	15	20
	Change in sleeping habits	10	15	20
	Change in residence	10	15	20
1.	Change in social activities	10	15	20
2.	Change in sleeping habits	10	15	20
3.	Change in residence	10	20	30
4.	Change in work hours	15	20	25
5.	Change in church activities	15	20	25
6.	Tension at work	20	25	30
7.	Small children in the home	20	25	30
8.	Change in living conditions	25	25	30
9.	Outstanding personal achievement	25	30	35
10.	Problem teenager(s) in the home	25	30	35
11.	Trouble with in-laws	25	30	35
12.	Difficulties with peer group	25	30	35
13.	Son or daughter leaving home	25	30	35
14.	Change in responsibilities at work	25	30	35
15.	Taking over a major financial responsibility	25	30	35
16.	Foreclosure of mortgage of loan	30	30	35
17.	Change in relationship with spouse	30	35	40
18.	Change to different line of work	30	35	40
19.	Loss of a close friend	35	35	40
20.	Gain of a new family member	35	40	45
21.	Sex difficulties	35	40	45
22.	Pregnancy	40	40	45
23.	Change in health of family member	40	45	50
24.	Retirement	45	45	50
25.	Loss of job	45	50	55
26.	Change in quality of religious faith	45	50	55
27.	Marriage	45	50	55
28.	Personal injury or illness	55	50	55
29.	Loss of self confidence	50	60	65
30.	Death of a close family member	50	60	70
31.	Injury to reputation	55	60	70
32.	Trouble with the law	55	65	75
33.	Marital separation	65	65	75
34.	Divorce	80	76	85
35.	Death of spouse		100	120
36.	Other (invalid in family; drug or alcohol problem, etc): _____			
37.	Other: _____			
		_____	_____	_____

Total of three columns

Scoring System:

(1) Greater than 300, highly significant life stress
(2) 200-300, significant life stress
(3) 150-200, moderate life stress
(4) Less than 150, low life stress

Environmental History Form	
What do you do for work?	Always wear proper personal protective equipment. Contact an Occupational and Environmental physician with questions about workplace exposures. www.aoec.org
Are you exposed to any of the following at work:	
Metals	
Solvents	
Chemicals (including those for cleaning)	
Radiation	
Fumes	
Lead can cause brain damage, especially in babies and children	Eat foods enriched with iron (lean red meats, chicken), calcium (dairy, green leafy vegetables), and vitamin C (oranges, grapefruits, tomatoes, green peppers).
Have you or anyone living in your house ever been treated for lead poisoning?	
Do you live in a house built before 1978?	Have your home tested for lead if it was built before 1978. Chipping paint may release lead into the house.
Are there any plans to remodel your home?	Avoid remodeling or hire a certified contractor. Call 1-800-424-LEAD for more information.
Have you ever lived outside the United States?	
Does your family use imported pottery or ceramics for cooking, eating, or drinking?	Imported pottery or ceramics may contain lead, which can leach into food.
Have you used any home remedies such as azarcon, greta, pay-loo-ah?	Do not use lead-containing home remedies.
Have you ever eaten any of the following:	Do not eat clay, soil, dirt, pottery, or paint chips because they may contain high levels of lead.
Clay	
Soil or dirt	
Pottery	
Paint chips	
Mercury is another metal that can damage the developing fetal brain. Small children are also sensitive.	It's important to clean up mercury spills in a special way. https://www.atsdr.cdc.gov/mercury/docs/residential_hg_spill_cleanup.pdf
Is there a mercury thermometer in your home?	Use a digital or mercury-free thermometer.
In general, do you eat fish more than twice a week?	Eat a variety of fish low in mercury twice a week. Contact local health dept. about local fish advisories.
Do you eat any of the following types of fish:	Do not eat shark, swordfish, king mackerel or tilefish because they contain high levels of mercury.
Shark	
King Mackerel	
Swordfish	
Tilefish	
Orange Roughy	
Big eye tuna	
Marline	
Albacore tuna ("white" tuna)	Albacore tuna contains more mercury than canned light tuna; do not eat more than 6 oz. per week of albacore tuna.
Air pollution is harmful to pregnant women who are "breathing for two" and also for fetuses, babies, and children.	

Do you plan on having rehab or painting done in your home during your pregnancy?	Avoid exposure to paint fumes, wood strippers, and other products containing solvents.
Do you use kerosene or gas space heaters?	Crack a window when using gas space heaters.
Do you live near an industrial site or busy roadway?	Avoid outdoor exercise on high air pollution days.
Do you use a wood burning stove for fireplace	Ensure adequate ventilation of wood burning stoves and fireplaces.
Does your home have a:	Smoke and carbon monoxide detectors should be installed on all floors and near bedrooms.
Smoke detector?	
Carbon monoxide detector?	
Does anyone who lives in your home smoke?	Make your home smoke-free.
Do any people who will be taking care of the baby smoke?	Avoid public places where smoking is allowed.
Pesticides have many potential health harms, both for babies and adults.	If you can afford fruits and vegetables grown without pesticides (including organic), you and your family will be exposed to less of these harmful chemicals.
Do you use pesticides? (bug killers, weed killers, rat poison)	Use Integrated Pest Management methods to control pests. Avoid sprays, foggers, and bug bombs. For more information go to the National Pesticide Information website http://npic.orst.edu/
Inside your home?	
Outside your home?	
On your pets?	
Healthy food and water are very important during pregnancy and for growing children.	
Do you use water or baby bottles made out of hard plastic or polycarbonate (#7)?	Polycarbonate plastic (even that labeled “BPA-free”) often contains BPA or similar chemicals which can interfere with hormones in the body, especially in developing fetuses.
Do you eat canned foods or food microwaved in plastic?	The linings of canned foods may contain a BPA-like additive. Microwaving in plastic increases the leaching of chemicals into food. Microwave in glass containers or ceramic bowls. Use a plate to cover a dish rather than plastic wrap.
Does your water come from a well?	Well water should be tested routinely for contaminants.
If your house is old, does it have lead pipes?	Run the tap for a minute or two to flush out sitting water.
Chemicals in personal care products, fragrances, and household cleaners may be harmful to pregnant women or fetuses.	
Do you use fragrant personal care products such as perfume, body spray, lotion, or shampoo/conditioner?	These products may contain chemicals such as phthalates which are thought to cause developmental problems for growing fetuses. Decrease the number of products you use, and purchase fragrance-free if possible.
Do you use products at home or work for cleaning or scent?	Cleaning chemicals may be harmful to pregnant women and to babies and children. Practice safe handling techniques if you have to use strong chemicals. Try to use less-toxic alternatives for cleaning such as vinegar, soap, and baking soda, or products certified as safer by third parties such as the EPA’s Safer Choice Program. Avoid air fresheners, incense, and scented candles.

Readiness Assessment and Health Goals

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Take several nutritional supplements every day	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Keep a record of everything you eat each day	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Modify your lifestyle (i.e. work demands, sleep habits)	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Practice a relaxation technique	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Engage in regular exercise	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities?	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

_____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1

Comments: _____

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